DEPARTMENT OF HEALTH SERVICES

*14/744 P STREET ;ACRAMENTO, CA 95814 (916) 445–1912



February 8, 1982

To: All County Welfare Directors

Letter No. 82-6

QUARTERLY SHARE OF COST (SOC)

This letter transmits the answers to the questions raised during the recent regional county training sessions. The questions and answers appear in Attachment I grouped by subject matter. If during your implementation new questions arise, please direct them to your Medi-Cal program consultant. If a sufficient number of questions of general applicability are received, another question and answer letter will be generated.

The State Printing Plant is experiencing some problems which may affect delivery of the revised Quarterly SOC forms. However, the initial supply of form MC 177S will be four part with blue carbon interleaf. Part one and two will be white paper, part three will be yellow and part four will be gold. This will only affect the initial supply and then we will return to the four part pink NCR paper. We expect all of the revised Quarterly SOC forms to be delivered to our warehouse by February 5, 1982. In order to speed up the delivery process please submit your forms request order (on the standard form) to the following address instead of the warehouse.

Department of Health Services Eligibility Branch 714 P Street, Room 1692 Sacramento, CA 95814 Attention: David Markell

If you have any questions contact your Medi-Cal program consultant.

Sincerely,

Original signed by

Madalyn M. Martinez, Chief Medi-Cal Eligibility Branch

Attachment

cc: Medi-Cal Liaisons

Medi-Cal Program Consultant

Expiration Date: July 30, 1982

A. Eligibility Questions

Intercounty Transfers (ICTs)

1. Question: When does the resonsibility shift from the initiating county to the new county for multi-month share-of-cost (SOC) cases?

Answer: The shift in responsibility should coincide with the SOC period; however, the new county of responsibility shall be given a minimum of 60 days in which to prepare for acceptance of the transfer.

Example: The SOC period established by County A is June-August. On July 15, County A initiates an ICT to County B. This case would remain the responsibility of County A through November, month of eligibility, unless County B agrees to accept responsibility effective September 1.

A post hearing change will be made to Section 50137 to more clearly state this policy.

Projection of Anticipated Income

2. Question: If a person will be starting a new job during an SOC period, how is staff to project mandatory deductions?

Answer: If the Medi-Cal regulations changing earned income deductions to standard amounts have not been filed by the time quarterly SOC is implemented, these are the guidelines that should be followed:

- a. Obtain as much information from the applicant as possible (e.g., are there mandatory union dues, health insurance premimums, amounts for meals withheld, retirement withholdings, number of dependents claimed for tax purposes, etc.?) The applicant may have to contact the future employer for some of this information.
- b. Assume that State Disability Insurance (SDI) will be withheld unless you have information to the contrary. This deduction is always one percent of the gross pay.
- c. Assume that Social Security Tax (Federal Insurance Contribution Act (FICA) or Old Age Survivors and Disability Insurance (OASDI)) will be withheld unless you have information to the contrary. Effective January 1, 1982, this deduction will be 6.7 percent of the gross pay.

For federal and state income tax withholding amounts, you can obtain copies of employer tax guides from IRS and Franchise Tax Board. (Probably one per office, kept in a central location, would be sufficient.) Based upon the number of dependents claimed and whether or not the individual meets the definition of head of household, the appropriate withholding amounts can be estimated.

If you believe an approach different from above would produce equally reliable results and would be more efficient, please submit your plan to us for approval. Any approved alternative will be shared with all county departments and state quality control staff.

SOC Periods

- 3. Some of the illustrations for determining SOC periods are included as Attachments II and III.
- 4. Question: Can the State consider simplifying the quarterly SOC concept by defining quarters as calendar quarters rather than using the month of application as the defining point?

Answer: This option was considered, however, based upon the federal regulations and written communications from federal staff, such a definition would result in a federal compliance issue. Even given the "flexibility changes" contained in PL 97-35, the Medicaid regulations require that states have a prospective budgeting system. Additionally, we have recently received correspondence indicating that, for retroactive eligibility determinations, states must consider the income in the three months prior to application in the SOC determination.

5. Question: The MFBU consists of an ABD-MN person and an MI spouse with a quarterly SOC period of June-August. The ABD-MN person enters LTC July 2 and returns to the home September 3. What are the share of cost periods?

Answer: Based upon input from county staff after the training a policy change has been made in this area. The change is that the spouse at home will keep the originally established threemonth period when the other spouse enters/leaves LTC. (Examples have already been distributed to the Medi-Cal Liaison in your county). This same policy applies when there are children in the home.

In the example above the SOC periods would be as follows:

June-August (ABD-MN/MI June and July; MI only August).

August (ABD-MN).

September-November (ABD-MN/MI September-November)

Note the ABD-MN should not be added until October if the action is adverse. In most instances the action will not be adverse. (See Question 11).

SOC Adjustments Due to Decreases in SOC

6. Question: If a person whose ongoing SOC is now zero due to an SOC adjustment, can the amount to be adjusted be "saved" and applied the next time changes in circumstances result in an SOC?

Answer: Yes. Regulations require that for persons who elect to have an overcharge adjusted in future periods, that the adjustment take place as soon as possible. Thus, if a person goes from an SOC to a lower SOC, the adjustment must begin immediately. If the person goes from an SOC to no SOC and still elects the adjustment method, the adjustment must be made as soon as the person again has an SOC.

Increase in SOC

7. Question: If an SOC increases during a multi-month SOC period, can MFBU meet the lower SOC and be certified for the month(s) in the period which are prior to the effective date of the change?

Answer: Yes, provided the lower SOC is met with medical expenses incurred prior to the effective date of the increase.

Example: A family is determined eligible with a \$50 SOC for May-July. On May 28, the family reports that an increase in income will occur in June. A Notice of Action is sent indicating that due to the increase in income which will be counted effective July 1 (because of ten-day notice requirements the increase cannot be reflected for the month of June), the SOC for the May-July quarter will be \$110. A new MC 177S is included with the Notice. On June 20, the original MC 177S is brought into the office. The family met the \$50 SOC on June 17. Since technically the increase for the May-July period is not effective until July 1, the family is entitled to cards for May and June after having obligated \$50. The MC 177S should be sent to Benefits Review Unit (BRU) with only the first two eligibility boxes checked. A supplemental MC 177S should be issued for July with a \$60 supplemental SOC amount (\$110-\$50).

Adding Persons to the MFBU

8. Question: How is a case processed when the inclusion of an excluded family member will increase the multi-month SOC after the MFBU has already met the SOC and received Medi-Cal cards?

Answer: Attachment IV outlines various case situations for a family with a \$90 multi-month SOC. The excluded son, when added to the MFBU, increases the multi-month SOC by \$10 each month. The increase is immediately computed since the inclusion of an excluded family member is not an adverse action per Section 50015.

Example 1 shows the MC 176M and MC 177S when the son is excluded from the MFBU.

Example 2 shows the MC 176M and MC 177S when the MFBU has met the SOC, received Medi-Cal cards for months A and B, and the son is to be included in the MFBU for months B and C.

Note: Only the son is listed as elgibile on the MC 177S for month B since the rest of the MFBU has met the SOC and received Medi-Cal cards. Everybody is listed as eligible on the MC 177S for month C since no one has received a Medi-Cal card.

Example 3 shows the MC 176M and MC 177S when the MFBU has met the SOC, received Medi-Cal cards for months A, B, and C, and the son is to be included in the MFBU for month C only.

Example 4 shows the MC 176M and MC 177S when the MFBU has met the SOC, received Medi-Cal cards for months A, B, and C, and the son is to be included in the MFBU for month C and also receive retroactive eligibility for months A and B, and month C of the prior multi-month period for the MFBU. The MFBU has already met the SOC and received Medi-Cal cards for the prior multi-month period.

Note: The son has a one-month SOC for month C of the prior multi-month SOC period. His income for months A and B of the prior period are not to be counted because he was not a member of the MFBU, and therefore, the entire multi-month period need not be reactivated in computing his SOC.

9. Question: When a family member, not currently on Medi-Cal, returns to the home, is that person's eligibility initially determined separately?

Answer: The evaluation of eligibility of such persons under a multi-month SOC system is the same as under the current monthly SOC system; that is, eligibility is evaluated both in terms of the individual and in terms of the impact upon the MFBU members. If either the individual does not meet the eligibility requirements or inclusion of the individual in the MFBU renders the entire unit ineligible, the individual is not added to the MFBU during the month of return.

Example: On March 8, it is reported that the absent parent returned to the home on February 27. When combining his/her property with the property of the MFBU, the entire family becomes ineligible. In this instance, the absent parent would not be added to the MFBU for March and the remaining family members would be terminated effective March 31, providing the property is not spent down.

There are instances in which the person returning to the home can establish separate eligibility during the month of return. For example, a 20-year-old who has been living independently is hospitalized and moves back with his/her parents to recuperate on May 18, giving up his/her former apartment. For the month of May, the 20-year-old can apply on his/her own because he/she was not living with the parents for part of the month. Beginning June 1, eligibility would be established in the parents' MFBU.

Adverse Actions

10. Question: Why is the addition of a voluntarily excluded child to the MFBU treated differently from the addition of a family member with income who has returned to the home; that is, the income of the formerly excluded child is considered in the SOC computation beginning with the month in which the child is placed in the MFBU, whereas the income of a person returning to the home is considered beginning with the first of the month following issuance of a ten-day notice if there will be an increased SOC even though the person is added to the MFBU immediately?

Answer: The reason for the difference stems from the current definition of adverse action. An increase in the SOC due to the inclusion of a voluntarily excluded person is defined as not being an adverse action. We are in the process of amending the definition of adverse action so that an increase in the SOC due to the addition of any family member to the MFBU is not an adverse action. Until this nonemergency regulation revision is filed, however, a ten-day notice must be given before increasing the SOC of the MFBU when a family member returns to the home.

11. Question: How do you determine whether a change in the SOC is an adverse action when you are combining two MFBUs into one?

Example: Mr. ABD-MN is in LTC with a monthly SOC of \$474 and his MI spouse at home has a zero quarterly SOC. Mr. returns to the home and the couple will have a \$198 quarterly SOC. Is this an adverse action for the MI spouse?

Answer: If the new SOC amount is equal to or less than the two SOCs combined, then the action is not adverse and a ten-day notice is not required. Thus, in the example above, the \$198 SOC is not an adverse action.

Implementation

12. Question: When quarterly SOC is implemented, how far back in time is it applicable?

Answer: The regulations became effective November 30, 1981; therefore, the multi-month SOC concept should be applied to December 1981 and forward months for which eligibility is being determined at time of implementation.

B. Procedural Questions

1. Question: When something like the aid code changes during the quarter, where is it shown on the MC 176 and MC 177?

Answer: There is space on the back of the MC 176 to notate changes occurring during the quarter. A note clearly explaining the change and the effective date should be attached to the MC 177 before submission to BRU.

2. Question: Do you list just the beginning month of eligibility for the SOC period at the top of the MC 176 or all of the months for the SOC period?

Answer: All months of the SOC period should be listed. This was inadvertently not done on the MC 176 examples distributed during training.

3. Question: Will BRU mail the BRU generated cards to the paper counties the way CID does?

Answer: No. BRU will mail the cards to the beneficiaries. Paper counties should follow the code-a-phone procedures for reporting changes to BRU.

4. Question: Will the MC 210 income section be revised to show three months of income information?

Answer: Yes; however, until the revision occurs, the county may choose to substitute the three-month quarterly status report form when obtaining income information at time of application.

5. Question: May the county still choose to send out Medi-Cal status reports on a monthly basis?

Answer: Yes.

6. Question: Can the county send changes to BRU in writing rather than use the code-a-phone procedures if changes are known in advance of card issuance by BRU?

Answer: No. All changes must be reported to BRU via the code-a-phone.

BEGINNING DATE SOC PERIOD

I.MO. OF ADD APP/EUG APZIL MAY JUNE , JULY AUG. SEPT

15 NO CF ELLC.

APP ELLG.

APRIL MAY JUNE JULL, AUG. SEPT. OCT.,

5 restorations

DISC.

APP

APRIL! MAY JUNE JULY ACG. SEPT.

JUNE JULY AUG. SEP

en Pa. PA reted sou 2.0N M/C PRIOR SOC MUST HEET PRIDE DISC. E. FEB. MARCH APRIL, MAY retro soc PRIOR SOC no conserve

I ABD COUPLE

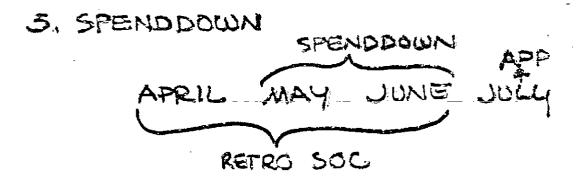
APRIL MAY JUNE

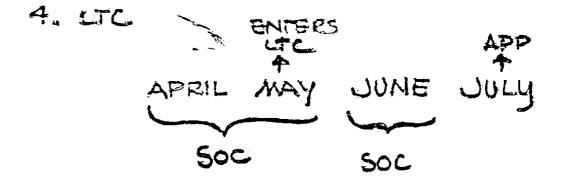
ABDIME ABOME ABOME AT HOME MEMBER

ABDIME APRIL MAY JUNE

REVISED SOC

ATT SOC





Decreases in soc

! CHANGE RE-PORTED TIME-LY

APRIL JAMU JUNE
10 15
0 15
0 15
0 EFFECTIVE

NGT INC. \$675 TD 579 NESDI 473 SOC *600 TO \$ 300

2. CHANGE NOT RPT. TIMBLY

APPLIL MAY JUNG
10
15
CHANGE EFFECTIVE
DECEASE RET UII

Ex. **50C** \$600

ALL 5 MO

Pec

1. Applies April 15; granted April 20.

2. Applies April 15, requests retro for Feb. & Mar.; granted April 20

Applies April 15; over property for April, but within property as of May 1; granted May 2.

Applies April 15; requests retro for Mar.; over property for April, but within property for Mar. & May; granted May 2.

5. Applies April 15; granted April 20; goes LTC on Aug 13.

Applies April 15; requests retro for Feb. & Mar.; AFDC eligible for Jan.; granted April 20.

Applies April 15; granted April 20; goes LTC on May 14; comes out of LTC on Sep. 2

7

D TH

348

APR

8. Applies April 15; requests retro for Jan., Teb. & Mar.; went into LTC on Teb. 14; granted April 20 unk Jul Oct Nov Dec .

لمر تسر المعرفة المعر

Requests discontinuance on Jan. 10 (effective Feb. 1); reapplies May 14; requests retro for Mer. & Apr.;

Requests discontinuance on Jan. 10 (effective Feb. 1); reapplies June 21; requests metro for Mar., Apr. 6 May; granted June 28.

ABD couple applies Jan 20; granted Feb. 7 for Jan.; one enters LTC on Feb. 10.

MI + ABD couple applies Jan. 20; granted Feb. 7 for Jan.; ABD enters LTC on Feb. {0.



APR MAY 4 ₹ua-

000

ĭ

HARE OF COST	DETERMIN	JATION N	ΛFBU± WHI	יסא כם אסו	TINCLUDE	LTC PERS	ONS A	Hickmen	+ ====	-1	
lase Name		XAW						County Distri		County Use	-
								Effective Eligi	DIRECTOR		
☐ New Application	n 🗆 Red	etermination	n 🗆 Char	ige 🗆 Reti	roactive Elig	. 🗆 Corr	ection	Mo. Apr-			
State i	lumber .				**************************************	Bint	idate	Sex (1) S	ocial Securit	v No. and	T
Ca. Aid 7 Digit Se	erial No. MF	Pers. BU No.	Name -	- First, Middle	, Last	Ma. D	ay Yr.	or Ra	ilth Insurance ilroad Retire	ment Na.	Coverage
7 850123	456 C) 0 L	arry	Larre	nce	91	4 38	$ \mathbf{m} _{(2)}^{(1)}.5.1$	2-34-	26.18	У
9 85 0123	456 0	loz m	lary	Larrer		62	ं उन	F. (2) 25/	2-98-1	165.4.	Y
9830123	j		anet	Larrer			4 69		22-34-		Y
Exclud	. 1		ohn b			7 -			21:.98		
- ckeue	lea r	1 1 0	JAN '	rarreno		-	(62	(1)			
						1		(2)			
					 			(2)			
1		hving as ASID					H (see	me of MFBU me			[
Income of MFBU (except PA or oth	er PA)		pius income i	or mouse or pr	iracić			apt PA or other		sted in i.	
A NONEXEMPT UP	NI DENRABE		Mon	ith 2	Mon	th 3	A, NO	EXEMPT UNE	ARNED INC	OME	
•		b.,		b.		b. Spouse or			Month 1	Month Z	Month 3
1	A8D-MN	Spouse or Parent	ABO-MN	Spouse of Parent	ABD-MN	Parent	1. \$0	cial Security			
1.Social Security 2.Net Income				<u> </u>		<u> </u>	·	rt income om property			
from Property						i		ner-Itemize		-	
3.Other-Itemize				<u> </u>		1	1		!		
4.						1	4.				
5.Total (add 1 thru 4)								· · · · · · · · · · · · · · · · · · ·			
6. Deductions								stat unearmed			
7.Remainder (5 minus 6)	a.	D.	a.	D.,	4.		la	dd 1 thru 4)	<u> </u>		
8, Combined un-			-								
earned income ladd 7a and 7b)						2.00	•	ountable un-	,		
9. Any Income deduction	_S20		-\$20	13.5 Photos	-\$20		í	med income minus 6}	 	,	一 >
10.Countable un-	1		-				BL N	ONEXEMPT EA	RNED INCO	ME :	
(8 minus 9)		3		100 km 200 100 km 200			·		Month 1	Month Z	Month 3
B. NONEXEMPT E	ARNED INCO		Mar	nth 2	Mor	rdi 3		ross earned			
		Spouse or	2.	b. Spouse or	L	Spouse or	<u> </u>	CG in last 4	900	l Lag	
	ABO-MN	Parent	ABD-MN	Parent	ABD-MN	Parent		os, enter \$30 3 remainder			
11.Gross Earned Income	<u> </u>			<u> </u>		1	1 30. 17	- James (CE)	18.00		2012 48
12 Deductions 13. Remainder	3.	5.	a.	D.	- a	0	10. 7	randatory.	200		
(11 minus 12) 14.Combined	ļ				1	2 (10 miles)	• 17 _	orte.	Arty	*	
earned Income (add 13a & 13b)		• • •				# 1 mm	2	clated_	75	1 400-	<u> </u>
15,565 earned Inc.						300 00 000 300 00 000 7 000 000	•	otal deduct. dd 9, 10, & 11)	275		
deduction plus \$ unused							3	ountable earned	625		
\$20 15. Remainder		****					1	come	1	<u> </u>	
(14 minus 15)	<u> </u>	200 C				7- 2 46(7)	C T	OTAL COUNTA	1	·	T
17:Countable earned income						4.03	14. Sc	abtotal	.Month 1	Month 2	Mc 3
(divide 16 by2)	ABLE INCOM	iE	-		1		(a	dd 7 and 131	625		
	Mor		Mor	nth 2	Mor	ਹਿ 3	لق أ	imony	}.	<u>}</u>	<u>}</u>
18. Total countable Income							In	otal countable	625		->>
(add 10 and 17)	<u> </u>					· · · · · · · · · · · · · · · · · · ·	<u> (1</u>	4 minus 15)	د ۸ ب		

		. mrcmice	1 144 2	Case Name:	
	Month 1	Month 2	Month 3		
1. Countable Income from 1 18					
2. Countable Income from II 16	625		>		•
3.inc. allocated from LTC/8&C person to family members at home (176W, Part IV)	-				
4. Combined countable Income (add 1, 2, and 3)	625			·	
ALLOCATIONS AND DEDUCTION	45				
5. Allocation to excluded children (176W, Fart !)	-	Officer Control		-	
6. Special deduction (176W, Part II)	-0-				
7, Income to determine PA Eligibility	-0-				
8. Health Insurance	12.50	100000000	>		_
9.	2733	-2.2			
10.			#1080 2144	•	
11. Total allocations/deductions (add 5 through 10)	12.50				
12. Total net nonexampt Income (4 minus 11)	612.50		>	SHARE OF COST	
13. Total net nonexempt Income rounded	613	613	613	13a. Total of Mos 1, 2, and 3	1839
14. Maintenance need	583	583	583	14a, Total of Mos. 1, 2, and 3	1749
				15. Share of cost (13a, minus 14a.)	90
	•	•		16. Underpayment adjustment	
				17. Adjusted Share of Cost (15 minus 16)	
IV. EXEMPT INCOME					

V. EXPLANATION OF CHANGES WITHIN S	cc	268100
------------------------------------	----	--------

te of California—Health and Welfare Agency di-Cal Program	EXAMM		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	CO DIST	COUNTY U
					Sonoma
CORD OF HEALTH CARE COSTS - SHARE OF COST		Only Medical expense following months may be	s in the isted below.	Share of Cost The amount that you	{
ad instructions on back before completing		Month A Month 8	Month C	must pay or obligate !	s: Re:
		.	. ~ 02	a/ 99	40
		Apr 82 may 82	Mo. Yr.	5	(Yes/r
		7			
ame .				•	
ddress .					
ity/State/Zip					
County	_				
49	or Charle of C	act			
Medical expenses of family members listed below may be used to be sometimes of the same of		in 1	Other Sex Cav. Soci	al Security No.	HIC or RR No.
Aid 7 Digit Serial No. FBU Pers. Name	- Last, First	A B C Mo. Day Yr.	M Y 512	34 5678	
85 0123456 0 01 Larrence,	mary	XXX 6 2039	F Y 512	98 7654	
85 0123456 0 02 Larrence 83 0123456 0 10 Larrence	Janet	XXX 5 14 69	F Y 527	<u>34 5678</u> 1 9876541	
Excluded Larrence	; John	++++7-7-65	7 3 3	3,87,63	
					<u>, , , , , , , , , , , , , , , , , , , </u>
Declaration of Provider: Each service listed below has payment or will seek payment from the patient for the payment of will seek payment and agree that I may			1 1 2 2 2 2 2 2	ioned provider, hereby	eclare th.
payment or will seek payment from the patient for that amount. I also understand and agree that I may This is the amount shown in the "Billed Medi-Cai" colu I understand that if I bill insurance or any other third party. I am aware that financial information on this form may Provider No.	be subject to scrutiny				Billed Med
PROVIDER NAME	Mo. Day Yr.			S	<u> </u>
PATIENT NAME					<u> </u>
PROVIDER SIGNATURE (See Declaration Above)					<u> </u>
PROVIDER NAME Provider No.			-		
PATIENT NAME					
PROVIDER SIGNATURE (See Declaration Above					1
Provider No.					
PROVIDER NAME Provider No.					
PATIENT NAME					
PROVIDER SIGNATURE (See Declaration Above)					
Provide: No.					
PROVIDER NAME					
PATIENT NAME					
PROVIDER SIGNATURE (See Declaration Above	,				
STATE USE ONLY	I have read	the instructions on the back of tred above in the "Billed Patient	this form. I agre t" column.	ie to assume full legal re	SPODZIBILITY TO
Mo. Day Yr. Reviewed By: Trans-	Replace	THE PRESENCE OF THE PROPERTY O			
	X	SIGNATURE OF APP	LICANT		DATE
Date of Certification	<u> </u>			<u> </u>	AMERICAN TANDER

EXAMPLE 1

HEACHMEN TIT

			DETER	MINA	ATION	 1 — N	1FBUs WHI	сн оо нот	INCLUDE	LTC PER	SONS	Attachm	ent II	\mathbf{I}		ساد العالم الدارية الجوافي ال
Case	Name		7	ΕX	An	7P	LE.	2				County Of	strict	C	ounty Use	7
	Vew .	Application						ge 🗆 Retr	oactive Eliq	Z □ Cor	rection	Effective i			or this Budge	
		State I	Number	•			······································		· · · · · ·	0:-						
Ca.	Aid	7 Digit S		MFBL	Pers.		Name -	- First, Middle,	, Last	İ	thdate Day Y	r. (2)	l Social Sec Health Insu Railroad Ri	ance	Claim Na.	Other Covers:
				<u></u>			····					(1)		• • •	• • • • • • • • • • • • • • • • • • • •	
				<u> </u>								(1) (2)	• • • • • • • • • • • • • • • • • • • •		• • • • • • •	
												(1)		• • •	• • • • • • •	
19	83	0123	456	0	11)	7	ohn l	arrenc	e	7 -	7 63	m (2)	521.98	3	1.6 5.4. .	Y
										. •		(1) (2)				
					:							(1)				
			Transcription of the second of						• ,=			(1).			• • • • • •	
l. [exceo. ucous	of MFBU	members er PA)	sopiy	ing as .	CBA	olus income o	f spouse or pa	rint			ncome of MFBU except PA or at		at lis	ted in I.	
		XEMPT U	YEARNE									IONEXEMPT U		INC	OME	
			· · · · · · · · · · · · · · · · · · ·	Month	Ъ.	<u> </u>	Mon	th 2	Mon	to 3 -	1	-	Month	1	Month 2	Month:
			ABD-M		Paren		ABD-MN	Spouse or Parent	ABO-MN	Spouse or Parent	1.	Social Security		<u>`</u>		
	iocial Vez In	Security came	<u> </u>							1	- 2.	Net Income from property			<u>_</u>	
	rom P	roperty									- 3.	Other-Itemize				
3.0	Other-	-Itemize									1	· · · · · · · · · · · · · · · · · · ·				
4.	Fatal							1			- 4.					
		thry 4)	<u> </u>]			1					-
	Remai		a.	<u> </u>	b.		2.) 	8,	6_	5.	Total unearmed				
	5 min	us 6)			,4:44			02130000		U.S. 1950es	6.	Deductions	- .			
•	amed	ned un- Lincome a and 7b)					<u>_</u>				7.	Countable un-				
	Any in Jeduci	icome tion	-520		Capp (1.46) (1.46) (1.46)		-520		- \$2 0			earned income (5 minus 6)	-			
		sbie un- I Income ius 9)			\$*** \$***					- 4	B.	NONEXEMPT	EARNED II	YCO!	ΜE .	
B. /	YONE	XEMPT E	ARNED !	NCOM	IE	·		33,700-40,330		- 30 40 40	<u> </u>		Month	. 1	Month 2	Month
•				Month	: 1 Ь.		Мол	th 2	Mor	1th 3	- 8.	Gross earned income			1100	
		<u> </u>	ABO-M		Spouse Parer		ABO-MN	Spouse, or Parent	ABO-MN	Spouse or Parent	9a.	If CG in last 4 mos, enter \$30		2		<u> </u>
_	Gross ncom	Earned e		1						-	96.	1/3 remainder				35.) 33 3.
	Deduc Remai		4.	-	b.		à.	b.	2.	1 8.	10.	mandel			250	
		inus 12)	<u> </u>			Street (1944)						- / - 0				11798 2862
. (Banec	income 3a & 13b)									:	Work Rel	<u> </u>		<u>106</u>	
15.3	65 48	irned Inc.	<u> </u>		350 260 200						1 12	Total deduct. (add 9, 10, & 1	1)		356	
;	\$	tion plus unused			T						13.	Countable earn	ed		744	
16.	320 Remai				200 000 000		·				3 3 c	TOTAL COUN	TARLE 1314	~~~·		<u> </u>
17,	Count		<u> </u>		944 () ()				·			.0.75.000	.Mond		Month 2	Mc
		i income ⊧ 16 by 2)			,60 							Subtotal		· · · · ·	744	<u> </u>
<u>c. </u>	TQTA	L COUNT	ABLE IN				1				15.	fadd 7 and 13) Child support/			/ 44	
		countable	1	Mont	1 1		Mor	1th 2	Mo	n th 3	16.	alimony Total countable	•			1
	ncom add 1	e 0 and 17)										Income (14 minus 15)			744	>

			Case Name:	
, Month 1	Month 2	Month 3		
·				
		-		.*
	744		-	****
ıs				
	S. co			
() in a s		3000 S		* · = · • =
		Single Control		
	pro-receipt of the second of t			
1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	,a			-
			·	
				-
			SHARE OF COST	
613		732.	13a. Total of Mos 1, 2, and 3	2077
583			14a. Total of Mos. 1, 2, and 3	1967
			15. Share of cost (134. minus 14a.)	110
•			16, Underpayment adjustment	
			17. Adjusted Share of Cost (15 minus 16)	
	613	Month 1 Month 2 744 12,50 12,50 12,50 731,50 732	Month 1 Month 2 Month 3	Month 1 Month 2 Month 3

V. EXPLANATION OF CHANGES WITHIN SOC PERIOD

5/12/82 mother reguested that son John be included in the MFBU for May and angoing. John was previously excluded

Eligibility Worker Signature

Worker Number Computation Date County Use

State of California -Hi ealth Medi-Cal Program	and	Welfare Agency	
MEDIATE LIGHTER			

EXAMPLE 2

Department of Health Still CO DIST COUNTY U

Sonome

HIBUNIYEN III

RECORD OF HEALTH CARE COSTS - SHARE OF COST Share of Cost Page Only Medical expenses in the READ INSTRUCTIONS ON BACK BEFORE COMPLETING following months may be listed below. The amount that you must pay or obligate is: Re. Month A Month B Month C 000 Jun 82 Mo. Name Address City/State/Zip County Code 49 Medical expenses of family members listed below may be used to meet Share of Cost Eligible Birthdate HIC or RR No. Sex Cov. State Number Social Security No. Name - Last, First Day Aid 7 Digit Serial No. FBU Pers. 34 5678 Y 5 2 \times 38 Mi Larry 101 85 0123456 0 512 98 7654 85 0123456 0 102 34 5678 3/0123456 0 10 Dane 83/0123456 Declaration of Provider: Each service listed below has been provided to the person listed on the date specified. I, the undersigned provider, hereby declare the payment of will seek payment from the patient for the amount shown in the "Billed Patient" column and that I will not accept payment from the Medi-Cal program for the costs of my service in excess of the amount billed to the patient amount is also understand and agree that I may seek payment from the Medi-Cal program for the costs of my service in excess of the amount billed to the patient is the amount shown in the "Billed Medi-Cal" column, and is the difference between the "Total Bill" and amount "Billed Patient". I understand that if I bill insurance or any other third party for the service rendered, I cannot list on this form the amount of the charge paid by the insurance or third party. I am aware that financial information on this form may be subject to scrutlny by the Internal Revenue Service and/or State Franchise Tax Board. Billed Medi-Billed Total Bill Proc. Code/ Date of Service SERVICE Provider No. Patient PROVIDER NAME Presc. No. Day 3 PATIENT NAME PROVIDER SIGNATURE (See Declaration Above) Provider No. PROVIDER NAME PATIENT NAME PROVIDER SIGNATURE (See Declaration Above) Provider No. PROVIDER NAME PATIENT NAME PROVIDER SIGNATURE (See Deciaration Above) Provider No. PROVIDER NAME PATIENT NAME PROVIDER SIGNATURE (See Declaration Above) I have read the instructions on the back of this form. I agree to assume full legal responsibility for the amounts listed above in the "Billed Patient" column. STATE USE ONLY TransJ Replace Reviewed By: Mo. Day DATE SIGNATURE OF APPLICANT 55800 -- CO 1,262M X. Cartification

						, , , , , , , , , , , , , , , , , , ,		١ ١ ١	/	****	
SHARE OF COST	DETERMIN	IATION - M	IFBUs WHI	тои са но	INCLUDE	LTC PERSO	≀ гис	Hachmen			ک ورست
Case Name	EX	AMP	LE	3_		-		County Distric		ounty Use	**************************************
☐ New Applicatio	_	etermination	v ⊠ Chan	oe Retr	oactive Elic	Corre	etion	Effective Eligit			
State N				2 WELL	- acure wild	Birth		T	ni트 xial Security	Yr. 8	2 .
Co. Aid 7 Digit Se	1	Pers.	Name -	- First, Middle,	Last	Mo. D.		(2) Hea	ith Insurance froad Retires	: Claim No.	Other Coverag
•								(1) (2)			
							· · · · · ·	(1)			
								(1)			
9 83 0123	456 0	111 3	John	Larren		7 7	63		1.98.7	65.H	У
1 00 0123	1300			HULLEN		:		(1)	• • • • • • •		
								(1)			
					·			(1) (Z)			
I. Income of MFBU (except PA or oth		lying as ASD	plus income o	of spouse or pa	rent			me of MFSU me eot PA or other?		ned in i.	 .
A. NONEXEMPT UN	EARNED IN			-				EXEMPT UNEA		OME 3MC	
e e	Mon	th 1 b.	Man	th 2	Mon	dn3 ·			Month 1	Month Z	Month 3
	ABD-MN	Spouse or Parent	ABD-MN	Spouse or Parent	ABD-MN	Spouse or Parent	1. So	cial Security			
1.Social Security								t Income			
2 Net Income from Property			····					m property her—Itemize	<u> </u>		
3, Other—Itemize			· · · · · · · · · · · · · · · · · · ·				i				
4.							4.	•			
S. Total [add 1 thru 4]											
6. Deductions 7. Remainder		10.	a.	٥.	1.	5.	la	ital uneamed come			
(5 minus 5)	a.]	a.		i .			dd 1 thru 41 Eductions			
8. Combined un- earned income			-			-					
Sadd 7a and 7b) Sadd 7b)				***************************************				ountable vn- med income			
deduction 10.Countable un-	-\$20	12.4	-\$20		-820		(5	minus õ)			
earned income (8 minus 9)		in a supplement			-	27 4	B. N	ONEXEMPT EA	RNED INCO	ME	
B. NONEXEMPT EA	RNED INC	OME							Month 1	Month Z	Month I
	Mor	refe 1 b.	Mor	nth 2 b.	Mor	ch 3) n	ross earned come			Noc
	ABO-MN	Spouse or Parent	ABO-MN	Spouss, or Parent	ABO-MN	Spouse or Parest		CG in last 4 os, enter \$30			i.
11. Gross Samed Income							95. 1/	3 remainder	35 (gr **) 15 (gr **) 12 (6**)		
12 Deductions 13. Remainder	8.	j i b.	[&.	5.	t.	۵.	10. M	and they		0.000 0.000 0.000	250
(11 minus 12)		0.00006000		· · · · · · · · · · · · · · · · · · ·	<u> </u>		11		Grande Grande		
earned Income (add 13a & 13b)						2217	11.ω	•	V (2000)		10
15,565 earned Inc.	1		<u> </u>				₹	otal deduct. dd 9, 10, & 11)			35
deduction plus \$ unused					. =		3	ountable samed			74
\$20 16.Remainder	1					25 To See To	1	OTAL COUNTA	BLE INCOM	<u>!</u> IE	
(14 minus 15) 17; Çauntable	<u> </u>		1		1	2000			.Month 1	Month 2	Мо
earned income (divide 16 by 2)			4	7,3.5		0 00 00 00 00 00 00 00 00 00 00 00 00 0	14. S	uptotal	1		742
C. TOTAL COUNT.	ABLE INCO		· I				15. C	hild support	 	,	, <u>, -3 -</u>
18. Total countable	Мо	ਕਈ 1	Mo:	nti Z	Mo	1क्त 3		imony otal countable	T ·		1
income (add 10 and 17)					}		11	rcome 14 minus 15)			744
MC 176M (9/\$1)	1	 	<u> </u>		 		-			-	

		THEOMETER	144	Case Name:	
	Month 1	Month 2	Month 3		
1, Countable Income from F 18					
2.Countable income from II 16			744		. •
3, inc. allocated from LTC/8&C person to family members at home (176W, Part IV)				-	*****
4. Combined countable Income (add 1, 2, and 3)			744		
ALLOCATIONS AND DEDUCTIONS	i				
5. Allocation to excluded children (176W, Part I)			(- <u>10 - 1</u>		
6. Special deduction (176W, Part II)			2000 T		
7. Income to determine PA Eligibility					
& Health Insurance		4 MATERIAL STATE	12.50		•
9.					
10.					÷
11. Total allocations/deductions (add 5 through 10)			12.50		
12. Total net nonexempt Income (4 minus 11)			731.50	SHARE OF COST	
13. Total net nonexempt Income rounded	613	613	732	13a. Total of Mos 1, 2, and 3	1958
14, Maintenance need	583	583	692	14a. Total of Mos. 1, 2, and 3	1858
				15. Share of cost (13a, minus 14a.)	100
				16. Underpayment adjustment	
				17. Adjusted Share of Cost (15 minus 16)	

V EYPLANATION OF CHANCES WITHIN COR SENIOR

6/14/82 mother phoned and reguested medi-Cal Bor John effective 6/1/82. John was previously excluded due to income.

Eligibility Worker Signature	Worker Number	Computation Date	County Use

State	cf	California	-Health	and	Weltare	Agency
vie di-	Ca	1 Scottsu				

											1	}Hac	hment	111-	<i>1</i>
									_		,		-		of Health St v
State of California Health and Welfare Agency	\mathcal{L}	XV	An	N F) [F	=		5					O DIST	COUNTYU
Medi-Cal Program		/ ` '	, , ,	• • •	•			_						1	Sonoma
RECORD OF HEALTH CARE COSTS - SHARE OF COST				1		On	ly Ma	dical	xpans	es in	the		Share	of Cost	Page
READ INSTRUCTIONS ON BACK BEFORE COMPLETING				Ì	fell	owi	ng mo	nths :	nay be	ilste	o beio	w.	The amou	int that yo	u Retrus
				1	Mor	stn /	4	Moi	ith B		Monti	7C	must pay o		
												,) <u> </u>	- N a
			-							J	un)	<u>82</u>	s(<u> </u>	No
				M	0.	_	Υr.	Mo.	уг	M	٥,	Yr.			(Yes/N
			•		ſ										
•				ļ	ı										
Name													•		
Address .															
City/State/Zip							-							•	
County															
49			_												
Medical expenses of family members listed below may be use	ed to m	est St	nare of	Cost					<u> </u>						
				L_	E}igl			Birthd		Sex	Other Cov.	Socia	al Security N	10.	HIC or RR No.
Ald 7 Digit Serial No. FBU Pers.	— Last,	-1134			/ 3	C	Mo	<u>- 03)</u> 14	38	m	Cooe	512	34 56	18	
85 0123456 0 01 Larrence,	يصا	ry			-	-	글	70			· ♦	512	9876		
85/0123456 0 07 Larrence	ma				+-	<u>}</u>	5	74	69	TE	Y	527		78	
83/0123456 6 10 Layrence,	<u> </u>					×	7		63		Y	52	9876	54	
9301234560 11 Larrence,	Jo	PV			+	1	<u> </u>			1	i				
					\top	Ť				Ī		ļ			
				İ	1	T									
Declaration of Provider: Each service listed below has	been or	ovided	to th	e perso	n lis	sted	on th	e date	specif	ec.	i, the	undersi not acc	gned provide sept paymen	er, nereby (t from the	Madi-Cal progra
payment or will seek payment from the patient in may s	eek Day	ment	from	the M	edi≺	Cati	progra	am to:	THE CO	7575 C	n iny :	Billed	Patient'.		
payment or will seek bayment and agree that I may set that amount. I also understand and agree that I may so This is the amount snown in the "Bilted Medi-Cal" column I understand that if I bilt insurance or any other third	nn, and	is the	differ • secula	enca D	etwe lares	een:≀ d.l.	саппо	t list	on this	tori	n the	amount	of the char	ge paid by	the insurance or
I understand that if I bill insurance or any other third inited party.	party :	Q1 (114	, , , , , , , ,			-•			- 5		ains s	tsta Fr	anchise Tax	Board.	
third party. I am aware that financial information on this form may	be subje	ect to	scrutir	ny by 1	the !	nter	nai K	evenu	e Servii	1	Proc.	Loge/	Total Bill	Billed	Billed Medi
PROVIDER NAME Provider No.	Date:	of Ser Day	vice :	SER	VIC	. E.					Presc.		s	Patient	s
				<u> </u>						+-				<u> </u>	
PATIENT NAME	1	į	ļ												·
(A)	<u>_</u>		<u> </u>	 						+					
PROVIDER SIGNATURE (See Deciaration Above)	1		 }												
Provider No.	<u> </u>		i	-											
PROVIDER NAME	i												1		1
PATIENT NAME	<u> </u>			1						T			1	1	
NWII Chai iachar			,							-			1		

PROVIDER NAME	Provider No.		of Se		SERVICE	Proc. Code/ Presc. No.	Total Bill	Patient	Billed McG
NOTICE ITEM		Ma.	Day 	1 77			\$	\$	\$
PATIENT NAME			1						
	; 		}	!					
PROVIDER SIGNATURE (See Decia	20011 AD016)		l 	 			ļ		
ROVIDER NAME	Provider No.		1	1			<u> </u>		
PATIENT NAME			 	1					
PROVIDER SIGNATURE (See Deci	eration Above)	1	<u>!</u>	1					
			<u>i</u>	<u> </u>			 	1	<u> </u>
PROVIDER NAME	Provider No.		1	!				<u> </u>	<u> </u>
PATIENT NAME				1					
PROVIDER SIGNATURE (See Decis	ration Above)	-	1	 					
			1	 			1		
PROVIDER NAME	Provider No.			1				<u> </u>	
PATIENT NAME				-					
PROVIDER SIGNATURE (See Deci	aration Above)	 		1					
PROVIDER SIGNATURE (SEE SEE				l 		e back of this form. I agree	to assume fo	ili legal resp	onsibility fo
STATE USE ONL	,	01		ounts	d the instructions on the listed above in the "Bille	ed Patient" column.			
Mo. Day Yr. Reviewed By:	Trans	M61140	•						
}	1		2	X	- Property Finds	OF APPLICANT		. 0	ATE
Date of					SIGNATURE	<u> </u>			57527-453 1,252

1412 U.C	OF COST	DETERM	in in it			CON GO HO			ONG.	Altrahm	00 F 777	- 1/->	
Case Nam		W. B. A. C.		11.500.1		4			.Crts	Attechme	111	County Use	
☐ New	Application	on 🗆 R	edeter	minatio	n 🖾 Chan	ige 🖾 Reti	roactive Elig	L Corr	ection	Effective Eligi Mo. Apr = 1			
	State	Number							ndat s	Sax (1) S	ocial Securit	v No. and	Τ΄ ΄
Co. Aid	7 Digit S	erial No. N		No.	Name -	- First, Middle	, Last	Mo. C	ay Yr.	(Z) Hea	ilth Insuranc ilroad Retira	z Claim No.	Other Coverage
								1	·····	(1)	· · · · · · · · ·	insit NO.	Coverad
							•			(2)			<u> </u>
	1		-							(2)			<u> </u>
	-							_		(z)	• • • • • • •		
19 83	012 34	156		11 3	John	Larre	nce	7 7	63	17 1 (2)	1:88:"	65#	Y
						<u> </u>				(1)		• • • • • •	
						,				(1)		• • • • • •	
	}								· · · · · · · · · · · · · · · · · · ·	<u> </u>			
l. Incon	ne of MFBU	members a	ppiyin	g as ABO	plus income o	of spouse or pa	irent		II. Inco	me of MFSU me	mbers not li	sted in I.	}
	et PA or et EXEMPT U		INCO	WE			<u></u>		(exc	rat PA or other	PAI		
		M	onth 1		Mon	th 2	Mon	th 3	A NON	EXEMPT UNE		1	
		4.		b. ouse or	٤.,	5. Spouse or	L	Spouse or		:	Month 1	Month 2	Month 3
1.Socia	I Security	A8D-MN	<u> </u>	,sueut	ABO-MN	Parent	ABD-MN	Parent		ział Security	<u> </u>		
2. Net i	ncame							<u></u>		t income m property			
	Property		+		<u> </u> 	<u> </u>	<u> </u>		3. 👓	per—(temiza		-	
3.Othe	r—i temize	1	+	*				<u> </u>		· · · · · · · · · · · · · · · · · · ·	1		<u> </u>
4. 5. Total			<u> </u>						4,		<u> </u>		l I I
(add	1 thru 41												
6, Degu										tal uncarned	<u> </u>		
7, Sema (\$ mi	ainder inus S)	a.	ь.		a.	b.	a.	<u> </u>	lac	d 1 thru 4)	1	<u> </u>	<u> </u>
	bined un- ed income			6 Tagain <u>-</u>	-			10 and 10				-	
(add	7a and 76)			A. 45				E 200	ř	untable un-			
9.Any dedu	Income ction	-520		To the second	-\$20	Strange Co.	-\$20		ł .	ned income minus 6)			
	table un-								B. NO	NEXEMPT EAR	ENED INCO	44E	<u> </u>
	inus 9)							er er er er er er er er er er er er er e			1		1
B. NON	EXEMPT E	т			1 4			-1-5	 8. Gc	oss sarmed	Month 1	Month 2	Month 3
			onth 1	ь.	Mon	b.	Mon	b.	inc	come	1100		
		ABD-MN		ouse or erent	ABD-MN	Spouse or Parent	ABO-MN	Spouse or Parent	mo	s, enter 530		, e	inguis James
tt.Grass Incor			Ì						96. 1/3	l remainder	**************************************		
12 Dedu								à.	10. M	udatory	200		<u> </u>
	ninus 12)	3.	1 6.	· · · · · · · · · · · · · · · · · · ·	2.	Ь.	a.			LOE TORY	250	- 08-0	
14,Comt	bined Id Income							/	11.W	ork Rel	106		
	13= & 135)			200		***************************************			4	tal deduct.	251		
- deduc	enied inc.							27 - E. Jak		untable earned	356	<u> </u>	
\$ \$20	unused			-					7	:om4	744		<u>></u>
16. Rema (14 m	sinder ninus 15)			*********		Company.		wast. S	C. TO	TAL COUNTA	BLE INCOM	E	
17:Coun	table d Income			***		7,000		: : : : : : : : : : : : : : : : : : :			Month 1	Month 2	Mor
(divid	te 16 by 2)	1		***************************************				5 . .	14. Su	btotal Id 7 and 13)	744		
C. TOTA	AL COUNT		ME onth 1	****					15. Ch	ild support/	}	}	1
	countable	<u> </u>	ynta I		mor	ith 2	Mon	th 3	16. To	tal countable			
Incon (add	ne 10 and 17)								1	ome (minux 15)	744]	 >
MC 1764				-			<u></u>		 				

	Month 1	Month 2	Month 3	
1. Countable Income from 1 18	Ϋ́			
2. Countable Income from II 16	744		>	
J. Inc., allocated from LTC/B&C person to family members at home (176W, Part IV)				_
Combined countable Income [add 1, 2, and 3]	744		>	•
ALLOCATIONS AND DEDUCTION	ts.			
Allocation to excluded children (176W, Part I)		<u> </u>	€9 <u>2</u> 0€	
Special deduction (176W, Part II)		agen mark Polym		
Income to determine PA Eligibility	1.00 Mg 3.00		7,40	
Health Insurance	12,50			
•				
				•
Total allocations/deductions (add 5 through 10)	12.50			
Total net nonexempt Income (4 minus 11)	731.50		——→	SHARE OF COST
Total net nonexempt Income rounded	732	732	732	13a. Total of Mos 1, 2, and 3
.Maintenance need	692	69Z	692	14a. Total of Mos. 1, 2, and 3
				,15. Share of cost (13a, minus 14a.)
	•			16, Underpayment adjustment
•				17. Adjusted Share of Cost (15 minus 16)

V. EXPLANATION OF CHANGES WITHIN SOC PERIOD

6/14/82.P/c Mrs. Larrence requested medi-al for John and retro eligibility back to march 82. John was previously excluded for a income.

I have read the instructions on the back of this form. I agree to assume full legal responsibility to amounts listed above in the "Billed Patient" column.

SIGNATURE OF APPLICANT

DATE

Department of Health Sun CO DIST COUNTY U

	ilifornia - Health an	IQ MAIL															!	ح ا	Sonomie
Medi-Cal P	Logram																<u> </u>		Page
RECORD	OF HEALTH CAF	E COS	TS - S	ARE OF COST					0	ly M	edical ex	penses	in ti	18	. 1		are of		1 200
RECORD	STRUCTIONS ON	BACK	REFOR	E COMPLETING				fo	silowi	ug w	outus wa	y be ilt	ted	perav	·	The ar	nount	that you bligate is	Re.
READ INS	STRUCTIONS UN	SACK	J					3.4	onth	A	Mont	h 8	M	tonth	c	must pa	ly of G	· Dilàtra (2	\
								\							1			·	
								١.				_		-	0.	•	30	00	Yes
								ĮΑρ	r 8	32	may	<u>82</u>	<u>ت.</u>	un	84	s`	<u></u>		(Yes/h
								Mo.		٧r.	Mo.	yr.	Mo.		Yr.]				
	2																		
							_	7		•									
								İ	ı										
	•																•		
Name																			
Address																			
								1	1										
City/Sta	te/ZIP								ـــا	_					•				
County	7 ·						_	_			•								
Cade	_																		
49	1																		
	and of family	v memt	pers ilste	ed below may be use	d to m	neet Sh	are of C	ast	igible	1			K	ther					HIG OF RR NO.
Medical	expenses of remm	•				. Gleet			<u>In</u>	1	Birtuda	-	iex (Cov.	Socia	i Securi	th uro.	<u> </u>	
	State Number		2 - 1	Name	— ∟ <u>as</u> t	, mirst		A	8 0		a. Day			V	512	34	567	8	
Aig	7 Digit Serial No.		Pers.	1	مسا	LYFY	/			10		<u> ~ </u>	m	$\frac{\cdot}{\cdot}$	A 17		765		
85	01234561	0	<u> </u>	Larrence,			,			6	20	39	F	<u>.</u>	212				
85	0123456	0	02	havience -	<u>~₩</u>	= .	4-			1.5	14	691	E	<u>_Y</u> _	522		<u>5</u> 67	<u>-, ii</u>	
	0123456	0	10	Larrence	- 2	<u></u>	<u> </u>	¥	X.	7 -	7 7	63	m	Y	521	98	76) <u></u>	
03	0123456	0	I II L	Larrence	, >	SON	<u> </u>	- ^	17	1 -	L.—-1—								
ہرم	0190199	1							╀╌┼		·								
		1							-						1			<u> </u>	
<u> </u>				te listed below has the patient for the									<u>. </u>	l *ne	undersi	gned or	ovider	, hereby (eclare t) /6
		<u> </u>	· · · · · · · · · · · · · · · · · · ·	e listed below has the patient for the agree that I may t	peen P	rovided	to the	perso	n liste	d on	the date	specsion	tnat	i wiii	not acc	ept pay	ment	from the	pilled to the p
Dec	laration of Provid	DSALLIS BL: EV	nt from	the patient for the	AMOU	int sho Themve	wn in t	77E 3	,,,,,,			The CO		it my	SELAICE	Ontient'		• • • • • • • • • • • • • • • • • • • •	
tue.	tamount laiso	underst			40 × ×		11 311	ne Ma	di-Ca	pro	ram for	1110 200	sts o	CHOL	Dellie		•		
101	E IE LINE STRICTS		and and	l agree that I may ! ited Medi-Cal* colur	nn, an	d is the	differe	ne Me nce be	di-Ca tweel	pro	gram for "Total 6	illi" and	sts o 2 am 1 ort	n the	amouni "Billed	of the	charge	paid by	ne insurance of
1 27			the "Bil	l agree that 1 may 1 led Medi-Cal " colur	nn, am	ior the	differe	nce be	tweet ared,	the can	"Total 6 not list	on this	torr	n the	amount	of the	charge	paid by	he insurance or
* 100	ngerstand that if i		the "Bil	l agree that 1 may 1 led Medi-Cal " colur	nn, am	ior the	differe	nce be	tweet ared,	the can	"Total 6 not list	on this	torr	n the	amount	of the	charge	paid by	he insurance of
thic	nderstand that if it rd party. m aware that finan		the "Bil	l agree that 1 may 1 led Medi-Cal " colur	party be sub	for the	differe service serutin	nce be	tweet ared,	the can	"Total 6 not list	on this	fort	n the	amount	of the	charge	paid by	Billed Medi
tnii Lai	nderstand that if i rd party, m aware that finan		the "Bil	agree that I may siled Medi-Cal ²² colur or any other third n on this form may Provider No.	party be sub	for the	differe service scrutin	nce be	tweet ared,	the can	"Total 6 not list	on this	fort	n the	amount	of the	charge	paid by	he insurance of
tnii Lai	nderstand that if it rd party- m aware that finan OVIDER NAME		the "Bil	agree that I may the ded may be ded medi-Cal? colur or any other third non this form may	party be sub	for the	differe service serutin	nce be	tweet ared,	the can	"Total 6 not list	on this	fort	n the	amount	of the	charge	Billed Patient	Bitled Medi
PRO	nderstand that if a rid party- m aware that finan		the "Bil	agree that I may the ded may be ded medi-Cal? colur or any other third non this form may	party be sub	for the	differe service scrutin	nce be	tweet ared,	the can	"Total 6 not list	on this	fort	n the	amount	of the	charge	Billed Patient	Bitled Medi
PRO	nderstand that if i rd party, m aware that finan		the "Bil	agree that I may the ded may be ded medi-Cal? colur or any other third non this form may	party be sub	for the	differe service scrutin	nce be	tweet ared,	the can	"Total 6 not list	on this	fort	n the	amount	of the	charge	Billed Patient	Bitled Medi
PRO	nderstand that II is red party. m aware that finan OVIDER NAME PATIENT NAME	cial inf	the "Bil surance ormatio	agree that I may to lied Medi-Call colur or any other third n on this form may provider No.	party be sub	for the	differe service scrutin	nce be	tweet ared,	the can	"Total 6 not list	on this	fort	n the	amount	of the	charge	Billed Patient	Bitled Medi
PRO	nderstand that II is red party. m aware that finan OVIDER NAME PATIENT NAME	cial inf	the "Bil surance ormatio	agree that I may to lied Medi-Call colur or any other third n on this form may provider No.	party be sub	for the	differe service scrutin	nce be	tweet ared,	the can	"Total 6 not list	on this	fort	n the	amount	of the	charge	Billed Patient	Bitled Medi
PRO	nderstand that if it ord party. m aware that finan IVIDER NAME PATIENT NAME PROVIDER SIGN.	cial inf	the "Bil surance ormatio	agree that I may to lied Medi-Call colur or any other third n on this form may provider No.	party be sub	for the	differe service scrutin	nce be	tweet ared,	the can	"Total 6 not list	on this	fort	n the	amount	of the	charge	Billed Patient	Bitled Medi
PRO	PROVIDER SIGN.	cial inf	the "Bil surance ormatio	agree that I may to lied Medi-Call colur or any other third n on this form may provider No.	party be sub	for the	differe service scrutin	nce be	tweet ared,	the can	"Total 6 not list	on this	fort	n the	amount	of the	charge	Billed Patient	Bitled Medi
PRO	nderstand that if it ord party. m aware that finan IVIDER NAME PATIENT NAME PROVIDER SIGN.	cial inf	the "Bil surance ormatio	agree that 1 may 1 lied Medi-Cal" colur or any other third n on this form may Provider No.	party be sub	for the	differe service scrutin	nce be	tweet ared,	the can	"Total 6 not list	on this	fort	n the	amount	of the	charge	Billed Patient	Bitled Medi
PRO	PATIENT NAME PROVIDER SIGN.	pill In	the "Bil surance ormatio	agree that 1 may 1 lied Medi-Cal" colur or any other third n on this form may Provider No.	party be sub	for the	differe service scrutin	nce be	tweet ared,	the can	"Total 6 not list	on this	fort	n the	amount	of the	charge	Billed Patient	Bitled Medi
PRO	PROVIDER SIGN.	pill In	the "Bil surance ormatio	agree that 1 may 1 lied Medi-Cal" colur or any other third n on this form may Provider No.	party be sub	for the	differe service scrutin	nce be	tweet ared,	the can	"Total 6 not list	on this	fort	n the	amount	of the	charge	Billed Patient	Bitled Medi
PRO	PATIENT NAME	cial inf	the "Bill surance ormatio	provider No.	party be sub Date Mo.	for the	differe service scrutin	nce be	tweet ared,	the can	"Total 6 not list	on this	fort	n the	amount	of the	charge	Billed Patient	Bitled Medi
PRO	PATIENT NAME	cial inf	the "Bill surance ormatio	provider No.	party be sub Date Mo.	for the	differe service scrutin	nce be	tweet ared,	the can	"Total 6 not list	on this	fort	n the	amount	of the	charge	Billed Patient	Bitled Medi
PRO	PATIENT NAME PATIENT NAME PATIENT NAME PROVIDER NAME PATIENT NAME PROVIDER NAME	cial inf	the "Bill surance ormatio	agree that 1 may 1 lied Medi-Cal" colur or any other third n on this form may Provider No.	party be sub Date Mo.	for the	differe service scrutin	nce be	tweet ared,	the can	"Total 6 not list	on this	fort	n the	amount	of the	charge	Billed Patient	Bitled Medi
PRO	PATIENT NAME PATIENT NAME PATIENT NAME PROVIDER NAME PATIENT NAME PROVIDER NAME	cial inf	the "Bill surance ormatio	provider No.	party be sub Date Mo.	for the	differe service scrutin	nce be	tweet ared,	the can	"Total 6 not list	on this	fort	n the	amount	of the	charge	Billed Patient	Bitled Medi
PRO	PATIENT NAME PATIENT NAME PATIENT NAME PROVIDER NAME PATIENT NAME PROVIDER NAME	cial inf	the "Bill surance ormatio	provider No. Provider No. Provider No.	party be sub Date Mo.	for the	differe service scrutin	nce be	tweet ared,	the can	"Total 6 not list	on this	fort	n the	amount	of the	charge	Billed Patient	Bitled Medi
PRO	PATIENT NAME PATIENT NAME PATIENT NAME PATIENT NAME PATIENT NAME PATIENT NAME PATIENT NAME PATIENT NAME PATIENT NAME	ATURE	the "Bill surance ormatio	provider No. Provider No. Provider No.	party be sub Date Mo.	for the	differe service scrutin	nce be	tweet ared,	the can	"Total 6 not list	on this	fort	n the	amount	of the	charge	Billed Patient	Bitled Medi
PRO	PATIENT NAME PATIENT NAME PATIENT NAME PROVIDER NAME PATIENT NAME PROVIDER NAME	ATURE	the "Bill surance ormatio	provider No. Provider No. Provider No.	party be sub Date Mo.	for the	differe service scrutin	nce be	tweet ared,	the can	"Total 6 not list	on this	fort	n the	amount	of the	charge	Billed Patient	Bitled Medi
PRO	PATIENT NAME PROVIDER NAME PATIENT NAME PATIENT NAME PATIENT NAME PATIENT NAME PATIENT NAME PATIENT NAME PROVIDER SIGN PATIENT NAME PROVIDER NAME PROVIDER NAME	ATURE	the "Bill surrance ormation or mation provider No. Provider No. Provider No.	party be sub Date Mo.	for the	differe service scrutin	nce be	tweet ared,	the can	"Total 6 not list	on this	fort	n the	amount	of the	charge	Billed Patient	Bitled Medi	
PRO	PATIENT NAME PROVIDER NAME PATIENT NAME PATIENT NAME PATIENT NAME PATIENT NAME PATIENT NAME PATIENT NAME PROVIDER SIGN PATIENT NAME PROVIDER NAME PROVIDER NAME	ATURE	the "Bill surrance ormation or mation provider No. Provider No. Provider No.	party be sub Date Mo.	for the	differe service scrutin	nce be	tweet ared,	the can	"Total 6 not list	on this	fort	n the	amount	of the	charge	Billed Patient	Bitled Medi	
PRO	PATIENT NAME PROVIDER NAME PATIENT NAME PATIENT NAME PATIENT NAME PATIENT NAME PATIENT NAME PATIENT NAME PROVIDER SIGN PATIENT NAME PROVIDER NAME PROVIDER NAME	ATURE	the "Bill surrance ormation or mation provider No. Provider No. Provider No.	party be sub Date Mo.	for the	differe service scrutin	nce be	tweet ared,	the can	"Total 6 not list	on this	fort	n the	amount	of the	charge	Billed Patient	Bitled Medi	
PRO	PATIENT NAME PROVIDER NAME PATIENT NAME PATIENT NAME PATIENT NAME PATIENT NAME PATIENT NAME PATIENT NAME PROVIDER SIGN PATIENT NAME PROVIDER NAME PROVIDER NAME	ATURE	the "Bill surrance ormation or mation provider No. Provider No. Provider No.	party be sub Date Mo.	for the	differe service scrutin	nce be	tweet ared,	the can	"Total 6 not list	on this	fort	n the	amount	of the	charge	Billed Patient	Bitled Medi	

Transa Replace

X

PATIENT NAME

Ma. Day

Date of

PROVIDER SIGNATURE (See Declaration Above)

Reviewed By:

STATE USE ONLY

Me Name				ICH DO NO.	MACCODE	CICIENS	042 1		111	12.	1 1 7
		EXAN	IPLE	_ 4				County Distri	ct	County Use	/ •
New Application					roactive Eli	g. 🖸 Corr	ection	Effective Elig			
	lumber						ndare		y Charles	Yr. &	<u> </u>
Co. Aid 7 Digit S	rial No. Mi	Pers.	Name -	– First, Middle	, Last	. Ma. E	Day Yr.	(2) He:	aith Insuranc iiread Resin	a Claim No.	1
		1						(2)	· · · · · · ·	ment No.	. Cove
						<u> </u>	· •	(1)	• • • • • • •		.
						- 	_	(2)			<u> </u>
7 83 0123	45/	2111	John	1		n n	17	M (2)	21-98	- 7654	
165 512.5	736 0	- 	20 NY	Larre	nce_	• 1	63	M (2)			
						· \		(2)			
					•			(2)		• • • • • •	1
Income of MFBU	members ao	olvina es ABC	olus income	of spoure of the	and		ll lese	me of MFSU me	• • • • • • •		4
(except PA or oth	er PAI						(exc	eat PA or ather	PA		
. NONEXEMPT OF	- Moi		Mod	nen Z	Mor	rth 3	A. NON	EXEMPT UNE	ARNED INC	OME	
	4	Spoum or		Spouse or		Spouse or		·	Month 1	Month 2	Mont
1. Social Security	ABD-MN_	Parent	ABD-MN	Parent	ABD-MN	Parent	1. Soc	ział Security	İ		
2. Net Income from Property					<u> </u>		1	t income m property	İ		
<u> </u>		<u> </u>					3. S a	ver—)cernize		·	
3. Other-Itemize		1				<u> </u>	<u>! </u>		!	<u> </u>	<u> </u>
S. Total		1	1 -		<u> </u>	<u>i</u> -	4.		•		
(add 1 thru 4) 6. Deductions		1		1		1			<u> </u>	ļ	<u> </u>
7. Remainder	4.) t.	a.	b.	å.	0.	inc	tal uneamed tome td 1 thru 41	<u> </u>		
(5 minus 6) 8, Combined un-		3.000000	<u> </u>	- 094.88M				ductions	<u>. </u>		
earmed income							7 0-		 	:	
9. Any income	-250	noticinate and the second	_sz0		-\$20		ear	untable un- ned income			
deduction Q.Countable un-					-320	* * Za.		minus 6)			
earned Income (8 minus 9)							E, NO	NEXEMPT EAI	RNED INCO	ME .	,
. NONEXEMPT EA	RNED INC	OME							Month 1	Month 2	Mont
	Moi	retfi 1	Mo	nth Z [b.	Mor	1th 3	Inc	ome earned			110
	ABD-MN	Spouse or Parent	ABD-MN	Spouse or Parent	ABO-MN	Spoure or Parent		CG in last 4 is, enter \$30		7004 1004	110
1. Gross Earned Income							96. 1/3	remainder			1
2. Deductions 3. Aemainder	a.	b.	3.	l c.	.	<u> </u>	10.1	1 1			25
(11 minus 12)		1700 20 000 000	•	in a contract to the contract			Ma	MANTORY	1		25
4.Combined *semed income /-del 12- * 1251		2					11.10	ork Rel	25-1	323	10
(add 13a & 13b) 5.565 samed Inc.							9	tal deduct. kt 9, 10, & 11)			35
deduction plus \$ unused		2		. 				untable earned]	<u> </u>	<u>J.</u>
\$20 6. Bemainder							Inc	:DMe	1	<u> </u>	7
(14 minus 15)		200				***************************************	<u>, </u>	TAL COUNTA	BLE INCOM	E	
7. Countable sarned income								······	Month 1	Month 2	Mont
(divior 16 by2)	BLE INCOM	4 E	<u> </u>			\$2.7 <u>7.7.7</u>	(ac	id 7 and 13)		•	74
-		nth 1	Mod	nth 2	Mor	ith 3	į.	ild support/ nony			
3. Total countable	MO.						<u>. </u>		<u> </u>	,	*

·	Month 1	Month 2	Month 3	Attachment III	14
1. Countable Income from 1 18				11.10.01.10.10.20	•
Z.Countable Income from II 16			744		
3.line, allocated from LTC/3&C person to family members at home (176W, Part IV)					.*
4. Combined countable Income (add 1, 2, and 3)			744	-	•
ALLOCATIONS AND DEDUCTIONS	5				
5. Allocation to excluded children (175W, Part I)		7	572	•	•
6. Special deduction (176W, Part II)					•
7.Income to determine PA Eligibility					
a. Health Insurance	2 AT		12.50		,
9.			12.50		
10.		, <u></u>			
11. Total allocations/deductions (add 5 through 10)					
12. Total net nonexempt Income [4 minus 11]	ī.		731.50	SHARE OF COST	
13. Total net nonexempt Income rounded	613	613	732	13a, Total of Mos 1, 2, and 3	11958
14, Main tenance need	583	<i>5</i> 83	692	14a. Total of Mos. 1, 2, and 3	185
				15. Share of cost [13a, minus 14a,]	100
	•		ĺ	16. Underpayment adjustment	1
				17. Adjusted Share of Cost (15 minus 16)	
IV.EXEMPT INCOME			<u></u>		

V. EXPLANATION OF CHANGES WITHIN SOC SERIO	V. 3	EXPLAN	MOITAN	as c	444655	WITCH	900	963104
--	------	--------	--------	------	--------	-------	-----	--------

See explanation on prior budget.

Eligibility Worker Signature Computation Date County Use

Reviewed By:

Date of

Transa Replace

State of California—Health and Welfare Agency EXAMPLE 4

Attachment 111

Department of Health Sin

CO DIST COUNTY U

DATE

								sonom
CORD OF HEALTH CARE COSTS - SHARE OF COST		Or	y Medical expe	nses in the		Share	of Cost	Pag
AD INSTRUCTIONS ON BACK BEFORE COMPLETING		followi	g months may		- 1.		nt that you r obligate is:	Retro.
		Month	Month (Montr	16		•	-
					0-	10	900	1 Y_
		<u> </u>		<u>Mar</u>	0	5		- TYes
		Mo.	Yr. Mo.	yr. Mo.	7 6 4 }			
							÷	
Dê						-		
gress								
y/State/Zin								
ounty		_;	•					
9								
	d to meet Share o	of Cost			· · · · · · · · · · · · · · · · · · ·		·	
dical expenses of family members listed below may be use State Number		Eligible	Birthdate	Sex Cov.	Social :	Security N	а. н	C or RR N
Name -	- Last, First	A B C	Mo. Day Y	Code				
5 0123456 0 01 Larrence,	Larry			8m H		34 <i>5</i> 6 78 76		
5 0123456 0 02 Larrence	marry		6 20 3			<u> 34 56</u>		
30123456 0 10 Larrence	James		5 146	3 m N			도세	
310123456 0 11 Larrence,	John	-						
		1						
Declaration of Provider: Each service listed below has be								
Declaration of Provider: Each Service Install and payment from the patient for the payment amount. I also understand and agree that I may see								
I understand that If I bill insurance or any other taird p	party for the serv	rice rendered, l	annot list on t	and amount? His form the a	mount o	f the charg	e paid by th	edi-Cai pro- pilled to the e insurance
This is the amount shown in the "Billed Medi-Cai" column I understand that If I bill insurance or any other third party. I am aware that financial information on this form may be	e subject to scrut	rice rendered, I stiny by the Inter	annot list on t	and amount the a vice and/or S	mount o	f the charg	e paid by th	e insurance
I understand that if I bill insurance or any other third print party. I am aware that financial information on this form may be a sware that financial information on the sware that financial information on the sware that financial information on the sware that financial information on the sware that financial information of the sware that financial information of the sware that financial information of the sware that financial information of the sware that financial information of the sware that financial information of the sware that financial information of the sware that financial information of the sware that financial information of the sware that financial information of the sware that financial information of the sware that financial information of the sware that financial information of the sware that financial information of the sware that financial information of the sware that financial information of the sware that fina	party for the serv	tiny by the Inter	annot list on t	and amount? His form the a	tate Fran	f the charg chise Tax (e paid by th Board. Billed Patient	Billed Me
I understand that if I bill insurance or any other third party. I am aware that financial information on this form may be provided NAME Provided NAME Provided No.	party for the service subject to scrut Date of Service	tiny by the Inter	annot list on t	vice and/or S	tate Fran	f the charg	e paid by th Board. Billed	e insurance
I understand that if I bill insurance or any other third p third party. I am aware that financial information on this form may be apply IDER NAME. Provider No.	party for the service subject to scrut Date of Service	tiny by the Inter	annot list on t	vice and/or S	tate Fran	f the charg chise Tax (e paid by th Board. Billed Patient	Billed Me
I understand that If I bill insurance or any other third party. I am aware that financial information on this form may be provided NAME PATIENT NAME PATIENT NAME	party for the service subject to scrut Date of Service	tiny by the Inter	annot list on t	vice and/or S	tate Fran	f the charg chise Tax (e paid by th Board. Billed Patient	Billed Me
I understand that if I bill insurance or any other third party. I am aware that financial information on this form may be provided NAME PATIENT NAME PROVIDER SIGNATURE (See Declaration Apove)	party for the service subject to scrut Date of Service	tiny by the Inter	annot list on t	vice and/or S	tate Fran	f the charg chise Tax (e paid by th Board. Billed Patient	Billed Me
I understand that If I bill insurance or any other third party. I am aware that financial information on this form may be provided NAME PATIENT NAME PATIENT NAME	party for the service subject to scrut Date of Service	tiny by the Inter	annot list on t	vice and/or S	tate Fran	f the charg chise Tax (e paid by th Board. Billed Patient	Billed Me
I understand that If I bill insurance or any other third printing party. I am aware that financial information on this form may be provider NAME PATIENT NAME PROVIDER SIGNATURE (See Declaration Above)	party for the service subject to scrut Date of Service	tiny by the Inter	annot list on t	vice and/or S	tate Fran	f the charg chise Tax (e paid by th Board. Billed Patient	Billed Me
I understand that if I bill insurance or any other third party. I am aware that financial information on this form may be provider NAME PATIENT NAME PROVIDER SIGNATURE (See Declaration Above)	party for the service subject to scrut Date of Service	tiny by the Inter	annot list on t	vice and/or S	tate Fran	f the charg chise Tax (e paid by th Board. Billed Patient	Billed Me
I understand that if I bill insurance or any other third plant overthird party. I am aware that financial information on this form may be provider NAME PATIENT NAME PROVIDER SIGNATURE (See Declaration Above) PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME	party for the service subject to scrut Date of Service	tiny by the Inter	annot list on t	vice and/or S	tate Fran	f the charg chise Tax (e paid by th Board. Billed Patient	Billed Me
I understand that If I bill insurance or any other third party. I am aware that financial information on this form may be provider NAME PATIENT NAME PROVIDER SIGNATURE (See Declaration Above) PATIENT NAME PROVIDER NAME PROVIDER SIGNATURE (See Declaration Above) PATIENT NAME PROVIDER SIGNATURE (See Declaration Above)	party for the service subject to scrut Date of Service	tiny by the Inter	annot list on t	vice and/or S	tate Fran	f the charg chise Tax (e paid by th Board. Billed Patient	Billed Me
PROVIDER SIGNATURE (See Declaration Above) PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER SIGNATURE (See Declaration Above) PROVIDER SIGNATURE (See Declaration Above)	party for the service subject to scrut Date of Service	tiny by the Inter	annot list on t	vice and/or S	tate Fran	f the charg chise Tax (e paid by th Board. Billed Patient	Billed Me
PROVIDER SIGNATURE (See Declaration Above) PROVIDER NAME PROVIDER NAME PROVIDER SIGNATURE (See Declaration Above) PATIENT NAME PROVIDER SIGNATURE (See Declaration Above)	party for the service subject to scrut Date of Service	tiny by the Inter	annot list on t	vice and/or S	tate Fran	f the charg chise Tax (e paid by th Board. Billed Patient	Billed Me
This is the amount shown in die I understand that If I bill insurance or any other third party. I am aware that financial information on this form may be provider NAME PATIENT NAME PROVIDER SIGNATURE (See Declaration Above) PROVIDER NAME PROVIDER SIGNATURE (See Declaration Above) PROVIDER SIGNATURE (See Declaration Above) PROVIDER SIGNATURE (See Declaration Above) PROVIDER NAME PROVIDER NAME Provider No.	party for the service subject to scrut Date of Service	tiny by the Inter	annot list on t	ris form the a	tate Fran	f the charg chise Tax (e paid by th Board. Billed Patient	Billed Me
PROVIDER SIGNATURE (See Declaration Above) PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER SIGNATURE (See Declaration Above) PROVIDER SIGNATURE (See Declaration Above) PROVIDER SIGNATURE (See Declaration Above) PROVIDER SIGNATURE (See Declaration Above) PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME	party for the service subject to scrut Date of Service	tiny by the Inter	annot list on t	vice and/or S	tate Fran	f the charg chise Tax (e paid by th Board. Billed Patient	Billed Me
This is the amount shown in die I understand that If I bill insurance or any other third p third party. I am aware that financial information on this form may b PROVIDER NAME PATIENT NAME PROVIDER SIGNATURE (See Declaration Above) PATIENT NAME PROVIDER NAME PROVIDER SIGNATURE (See Declaration Above) PROVIDER SIGNATURE (See Declaration Above) PROVIDER SIGNATURE (See Declaration Above) PROVIDER NAME PROVIDER NAME PROVIDER NAME Provider No.	party for the service subject to scrut Date of Service	tiny by the Inter	annot list on t	ris form the a	tate Fran	f the charg chise Tax (e paid by th Board. Billed Patient	Billed Me
This is the amount shown in sile of the state of the party. I understand that If I bill insurance or any other third party. I am aware that financial information on this form may be provided that the provider No. PATIENT NAME PROVIDER SIGNATURE (See Declaration Above) PROVIDER SIGNATURE (See Declaration Above) PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER SIGNATURE (See Declaration Above) PATIENT NAME PROVIDER SIGNATURE (See Declaration Above)	party for the service subject to scrut Date of Service	tiny by the Inter	annot list on t	ris form the a	tate Fran	f the charg chise Tax (e paid by th Board. Billed Patient	Billed Me
This is the amount shown in the litting party. I understand that If I bill insurance or any other third party. I am aware that financial information on this form may be provided that the provider No. PATIENT NAME PROVIDER SIGNATURE (See Declaration Above) PATIENT NAME PROVIDER SIGNATURE (See Declaration Above) PROVIDER SIGNATURE (See Declaration Above) PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME	party for the service subject to scrut Date of Service	tiny by the Inter	annot list on t	ris form the a	tate Fran	f the charg chise Tax (e paid by th Board. Billed Patient	Billed Me
This is the amount shown in the form any other third party. I understand that If I bill insurance or any other third party. I am aware that financial information on this form may be provider Name PROVIDER NAME PROVIDER SIGNATURE (See Declaration Above) PROVIDER SIGNATURE (See Declaration Above) PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER SIGNATURE (See Declaration Above) PROVIDER SIGNATURE (See Declaration Above) PROVIDER SIGNATURE (See Declaration Above) PROVIDER SIGNATURE (See Declaration Above)	party for the service subject to scrut Date of Service	tiny by the Inter	annot list on t	ris form the a	tate Fran	f the charg chise Tax (e paid by th Board. Billed Patient	Billed Me
I understand that if I bill insurance or any other third per third party. I am aware that financial information on this form may be provider NAME PROVIDER NAME PROVIDER SIGNATURE (See Declaration Above) PROVIDER SIGNATURE (See Declaration Above) PROVIDER SIGNATURE (See Declaration Above) PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER SIGNATURE (See Declaration Above)	party for the service subject to scrut Date of Service	tiny by the Inter	annot list on t	ris form the a	tate Fran	f the charg chise Tax (e paid by th Board. Billed Patient	Billed Me
This is the amount shown in a life in the provider that If I bill insurance or any other third party. I am aware that financial information on this form may be provider NAME PROVIDER NAME PROVIDER SIGNATURE (See Declaration Above) PROVIDER NAME PROVIDER SIGNATURE (See Declaration Above) PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER SIGNATURE (See Declaration Above) PROVIDER SIGNATURE (See Declaration Above) PROVIDER SIGNATURE (See Declaration Above) PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME	party for the service subject to scrut Date of Service	tiny by the Inter	annot list on t	ris form the a	tate Fran	f the charg chise Tax (e paid by th Board. Billed Patient	Billed Me
This is the amount shown in the street in the provider that If I bill insurance or any other third party. I am aware that financial information on this form may be provider NAME PROVIDER NAME PROVIDER SIGNATURE (See Declaration Above) PROVIDER SIGNATURE (See Declaration Above) PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER NAME PROVIDER SIGNATURE (See Declaration Above) PROVIDER SIGNATURE (See Declaration Above) PROVIDER SIGNATURE (See Declaration Above)	Date of Service Mo. Day Yr.	tiny by the Inter	annot list on t	rand amount his form the a vice and/or S Proc. C Presc.	Billed Fan mount o tate Fran ode/ No.	f the chargechise Tax E Total Bill S	e paid by th Board. Billed Patient S	Bitled Me \$

SIGNATURE OF APPLICANT